HEPATITIS B and DELTA HEPATITIS CASE INVESTIGATION - Page 1 of 5

Indiana State Department of Health
State Form 52587 (2-06)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

1. Print firmly and neatly.
2. Only use pens with blue or black ink.
3. Fill in circles like this: ● Not like this: ⊗ ✓ Mark mistakes like this: ✗●
4. Print capital letters only and numbers completely inside boxes. A 2 C 3
5. Please complete all items on form.
6. **Date format: MM/DD/YY**

Section 1. Demographic Information

Last Name

First Name **MI** **Phone Number** - -

Number & Street Address

City **State** **ZIP Code** -

County **Date of Birth** / / **Age**

Race:
- ○ Asian
- ○ Black or African American
- ○ American Indian or Alaska Native
- ○ Native Hawaiian or Other Pacific Islander
- ○ White
- ○ Other/Multiracial
- ○ Unknown

Ethnicity:
○ Hispanic or Latino ○ Not Hispanic or Latino ○ Unknown

Sex:
○ Male ○ Female ○ Unknown

Is Age in day/mo/yr?
- ○ Days
- ○ Months
- ○ Years

Occupation **Phone of Employer/School/Day Care** - -

Name of ○ **Employer** ○ **School** ○ **Day Care**

Address of Employer/School/Day Care

City **State** **ZIP Code** -

Section 2. Clinical Data

Name of Health Care Provider

Address

City **State** **ZIP Code** -

Phone Number - -

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Section 2. Clinical Data (Continued)

Pregnancy status for all females 12-50 years old.

Is the patient pregnant?

○ Yes ○ No ○ Unknown ___/___/___
If Yes, due date

If Yes, complete and attach Perinatal Hepatitis B Case Report - State Form _____

Reason for testing (check all that apply):

○ Symptoms of Acute Hepatitis
- ○ Fever
- ○ Diarrhea
- ○ Nausea/Vomiting
- ○ Abdominal Pain
- ○ Pale Stool
- ○ Dark Urine
- ○ Fatigue
- ○ Loss of Appetite
- ○ Jaundice
- ○ Other, specify: _____

___/___/___
Date of Onset

___/___/___
Date of Diagnosis

___
Duration of Symptoms in Days

___/___/___
Date First Positive Specimen Collected

○ Evaluation of Elevated Liver Enzymes

○ Screening of Asymptomatic Patient with Reported Risk Factors

○ Screening of Asymptomatic Patient with No Risk Factors (e.g., Patient Requested)

○ Blood/Organ Donor Screening

○ Follow-up Testing for Previous Hepatitis B Marker

○ Prenatal Screening

○ Other, specify: _____

○ Unknown

Diagnostic tests (check all that apply):

Hepatitis B surface antigen (HBsAg)	○ Positive	○ Negative	○ Unknown
Total antibody to hepatitis B core antigen (Total anti-HBc)	○ Positive	○ Negative	○ Unknown
IgM antibody to hepatitis B core antigen (IgM anti-HBc)	○ Positive	○ Negative	○ Unknown
Antibody to hepatitis D virus (anti-HDV)	○ Positive	○ Negative	○ Unknown

Liver enzyme levels at time of diagnosis:

ALT (SGPT) Results: ____ Upper limit normal: ____ Date of ALT: ___/___/___

AST (SGOT) Results: ____ Upper limit normal: ____ Date of AST: ___/___/___

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Section 2. Clinical Data (Continued)

Was the patient hospitalized for hepatitis B or delta hepatitis?

◯ Yes ◯ No ◯ Unknown

If Yes, admission date: ___ / ___ / ___

Discharge date: ___ / ___ / ___

Hospital: _____

Did the patient die from hepatitis?

◯ Yes ◯ No ◯ Unknown

If Yes, date of death: ___ / ___ / ___

Section 3. Diagnosis

Please select one.

◯ Acute Hepatitis B

◯ Chronic Hepatitis B

◯ Perinatal Hepatitis B Infection (Complete Perinatal Hepatitis B Case Report - State Form 52589)

◯ Delta Hepatitis Infection

Patient education, contact follow-up, and vaccination will be done by:

◯ Local Health Department ◯ Health Care Provider ◯ Other, specify: _____

Section 4. Risk Factors for Acute Hepatitis B Cases Only

During the **6 weeks-6 months** prior to onset of symptoms:

Was the patient a contact of a person with confirmed or suspected acute or chronic hepatitis B infection?

◯ Yes ◯ No ◯ Unknown

If Yes, specify type of contact:

◯ Household Member (non-sexual)

◯ Sex Partner

◯ Other, specify: _____

Regardless of the patient's gender, how many

1. **Male sex partners did the patient have?**
   ◯ 0 ◯ 1 ◯ 2-5 ◯ >5 ◯ Unknown
2. **Female sex partners did the patient have?**
   ◯ 0 ◯ 1 ◯ 2-5 ◯ >5 ◯ Unknown

Did the patient inject drugs not prescribed by a doctor?

◯ Yes ◯ No ◯ Unknown

Did the patient use street drugs but not inject?

◯ Yes ◯ No ◯ Unknown

Did the patient undergo hemodialysis?

◯ Yes ◯ No ◯ Unknown **If Yes, date:** ___ / ___ / ___

Did the patient have an accidental stick or puncture with a needle or other object contaminated with blood?

◯ Yes ◯ No ◯ Unknown **If Yes, date:** ___ / ___ / ___

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Section 4. Risk Factors for Acute Hepatitis B Cases Only (continued)

Did the patient receive blood or blood products (transfusion)?

○ Yes ○ No ○ Unknown **If Yes, date:** ___ / ___ / ___

Did the patient receive any IV infusions and/or injections in an outpatient setting?

○ Yes ○ No ○ Unknown **If Yes, date:** ___ / ___ / ___

Did the patient have exposure to someone else's blood?

○ Yes ○ No ○ Unknown **If Yes, date:** ___ / ___ / ___

If Yes, specify

Did the patient have dental work or oral surgery?

○ Yes ○ No ○ Unknown **If Yes, date:** ___ / ___ / ___

If Yes, name of provider

Did the patient have surgery (other than oral surgery)?

○ Yes ○ No ○ Unknown **If Yes, date:** ___ / ___ / ___

If Yes, name of surgeon

Was the patient hospitalized overnight for any reason?

○ Yes ○ No ○ Unknown **If Yes, date:** ___ / ___ / ___

If Yes, name of hospital

Was the patient a resident in a long-term care facility?

○ Yes ○ No ○ Unknown **If Yes, date:** ___ / ___ / ___

If Yes, name of facility

Was the patient incarcerated for longer than 24 hours?

○ Yes ○ No ○ Unknown **If Yes, date:** ___ / ___ / ___

If Yes, type of facility (check all that apply):

○ Prison ○ Jail ○ Juvenile Facility

Did the patient have any part of his/her body pierced (other than ear)?

○ Yes ○ No ○ Unknown **If Yes, date:** ___ / ___ / ___

If Yes, indicate where the piercing was performed (check all that apply):

○ Commercial Parlor/Shop ○ Correctional Facility

○ Other, specify: ___

Did the patient have an ear pierced?

○ Yes ○ No ○ Unknown **If Yes, date:** ___ / ___ / ___

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Section 4. Risk Factors for Acute Hepatitis B Cases Only (continued)

Did the patient have a tattoo placement?

○ Yes ○ No ○ Unknown **If Yes, date:** ___ / ___ / ___

If Yes, indicate where the tattoo placement was performed (check all that apply):

○ Commercial Parlor/Shop ○ Correctional Facility

○ Other, specify: _____

Was the patient employed in a medical or dental field involving direct contact with human blood?

○ Yes ○ No ○ Unknown

If Yes, check frequency of direct blood contact:

○ Frequent (several times/week) ○ Infrequent

Was the patient employed as a public safety worker (fire fighter, law enforcement or correctional officer) having direct contact with human blood?

○ Yes ○ No ○ Unknown

If Yes, check frequency of direct blood contact:

○ Frequent (several times/week) ○ Infrequent

Section 5. Lifetime Risk Factors

Was the patient ever treated for a sexually transmitted disease?

○ Yes ○ No ○ Unknown

If Yes, in what year was the most recent treatment? ____

Was the patient ever incarcerated for longer than 6 months duration?

○ Yes ○ No ○ Unknown **If Yes, most recent year:** ____

Length of incarceration: ___ **months.**

Section 6. Vaccine Information

Did the patient ever receive hepatitis B vaccine?

○ Yes ○ No ○ Unknown **If Yes, number of doses:** ___

Year the last dose was received: ____

Was the patient tested for hepatitis B antibody (anti-HBs) within 1-2 months after the last dose?

○ Yes ○ No ○ Unknown

If Yes, was the anti-HBs result 'positive' or 'reactive' ?

○ Yes ○ No ○ Unknown

Section 7. Comments/Follow-up

Comments:

_____

InvestigatorName

_____

Agency

___ - ___ - ____ ___ / ___ / ___

PhoneNumber **Date**